

Most Older Women Not Being Advised to Exercise

BY DIANA MAHONEY
New England Bureau

NEW ORLEANS — Counseling about the health benefits of exercise is reaching fewer than one in three women over age 50, a national survey has shown.

Studies have shown that exercise can reduce a woman's risk of hip fracture, depression, arthritis pain, diabetes, and coronary artery disease, and that it can improve longevity and cognitive function. Yet a survey of 6,385 women over age 50 showed that only 31% of those aged 50-64 years had been counseled by their physicians to begin or continue any type of physical activity, reported Mara A. Schonberg, M.D.

The older the woman—regardless of functional status or comorbid illness—the less likely she was to have received exercise counseling. Only 29% of those aged 65-74 years received exercise counseling from their physicians, and only 22% of those aged 75-84 years and 14% of those aged 85

and older got such advice, Dr. Schonberg reported at the annual meeting of the Society of General Internal Medicine.

Dr. Schonberg and colleagues at Beth Israel Deaconess Medical Center in Boston used data from the National Center for Health Statistics' 2000 National Health Interview Survey to identify women aged 50 or older who had seen a health care provider during the previous year.

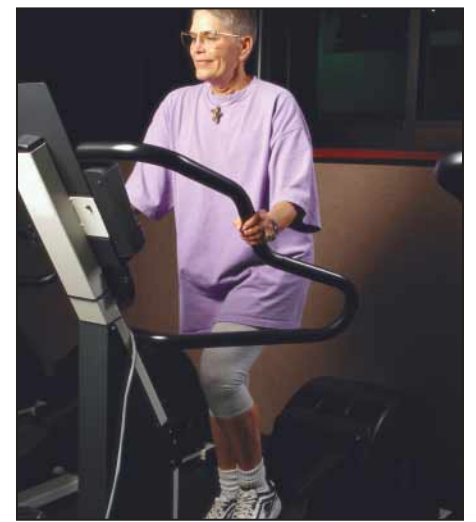
The investigators compared clinician counseling about exercise across the four age categories noted above, using multivariable logistic regression to adjust for demographic factors, body mass index, physical activity, smoking status, having a usual source of care, and number of doctor visits within the previous year. They used additional models to assess the influence of illness burden and functional status on exercise counseling habits.

The initial, unadjusted model showed that for women aged 75-84 years and those aged 85 and older, the odds ratios for re-

ceiving exercise counseling were 0.8 and 0.6, respectively, compared with younger women. When the illness burden was taken into account, the odds ratios dropped to 0.7 and 0.5 for women aged 75-84 years and those aged 85 and older, respectively.

One "surprise" finding was that "the differences in exercise counseling across the age groups were more pronounced for women with less comorbidity than those with greater comorbidity," Dr. Schonberg said. For example, the odds ratio for exercise counseling was 0.4 for women aged 85 or older with fewer than two comorbidities, compared with women aged 50-64 years with the same comorbidity, while it was 0.7 for women older than 85 with two or more comorbidities. This trend was consistent across all age groups.

These findings suggest that age is a conceptual barrier to clinicians discussing exercise with patients, despite awareness of the benefits of physical activity. "The greatest disparity is among older women



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with less illness burden," said Dr. Schonberg, noting that efforts should be made to increase provider exercise counseling for such patients. ■

Sustained Weight Loss Improves Symptoms of Knee Osteoarthritis

BY BRUCE JANCIN
Denver Bureau

VIENNA — Obese individuals with knee osteoarthritis who successfully lose 11% of their body weight and keep it off for a year can reasonably expect a 20% improvement in knee symptom scores, Robin Christensen reported at the annual European Congress of Rheumatology.

This is a moderate to large treatment effect. Clinically, it's as good as or better than can be achieved with current drug therapy—and without the side effects, said Mr. Christensen of Frederiksberg Hospital, Copenhagen.

He presented a 1-year randomized trial in which 89 obese patients with knee osteoarthritis were assigned to an intensive dietary intervention featuring weekly counseling sessions, with an emphasis upon a low-energy diet, or to a control group that got standard dietary counseling on four occasions during the year. Patients averaged 63 years of age, with a mean baseline body mass index of 36 kg/m².

At year's end, the intervention group had lost a mean of 10.9 kg, or 11% of baseline weight, while controls lost 3.3 kg, or 3%. Overall, 55% in the intervention arm and 9% of controls managed to sustain at least a 10% weight loss.

The key study finding: Patients in the intensive-diet arm experienced a mean 20% reduction in their total Western Ontario and McMaster Universities Os-

teoarthritis Index (WOMAC) scores from a baseline of 936, while there was no significant change in WOMAC scores in the control group. Mr. Christensen and his coworkers calculated that for each 1% reduction in body weight maintained for a year, WOMAC scores improved by at least 15 points.

This yearlong study follows an earlier 8-week randomized trial by the same Danish investigators, in which they showed that more than



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DR. LOHMANDER

one in four obese patients with knee osteoarthritis randomized to an intensive 8-week weight loss program experienced at least a 50% improvement in WOMAC scores. (*Osteoarthr. Cartil.* 2005;13:20-7).

The new trial was undertaken to learn if weight loss and the resultant improvement in osteoarthritis could be maintained long-term, Mr. Christensen said at the meeting, sponsored by the European League Against Rheumatism.

In a separate presentation, Stefan Lohmander, M.D., observed that while there is good epidemiologic evidence to suggest even fairly modest changes in body weight have a dramatic influence on knee osteoarthritis, only within the past year have confirmato-

ry randomized interventional trial data become available. The evidence has been provided by the Danish group as well as by a study from Wake Forest University which concluded a diet-plus-exercise regimen was more effective than either alone (*Arthritis Rheum.* 2004;50:1501-10).

Sustained weight loss, while often a daunting challenge, will be perceived by many patients as an increasingly attractive therapeutic alternative in light of all the recent turbulence surrounding the nonsteroidal anti-inflammatory agents, the pharmacologic mainstay in osteoarthritis therapy, predicted Dr. Lohmander, professor of orthopedics at Lund (Sweden) University.

Two theories have been proposed to explain the association between obesity and knee osteoarthritis. One is biomechanical; it holds that obesity causes repetitive loading at the knee joint which eventually exceeds the joint's load-bearing capacity and causes symptomatic osteoarthritis.

The other explanation focuses upon metabolic factors. It's known, for example, that one-third of circulating interleukin-6, an inflammatory cytokine important in rheumatologic diseases, is secreted by fat cells. Moreover, cartilage cells are known to be insulin sensitive, and it's possible insulin resistance impairs their function. Dietary weight loss has been shown to result in reductions in a number of inflammatory markers elevated in osteoarthritis, he observed. ■

Agility, Perturbation Exercises Enhance Stability In Knee Osteoarthritis

CHICAGO — Agility and perturbation exercises may enhance knee stability and function in patients with knee osteoarthritis, G. Kelley Fitzgerald, Ph.D., reported at a symposium sponsored by the American College of Rheumatology.

Knee instability is a common problem in knee osteoarthritis (OA) and affects physical function beyond what can be explained by knee pain and muscle weakness, said Dr. Fitzgerald, a physical therapist at the University of Pittsburgh.

In an study of 105 patients with knee OA, Dr. Fitzgerald found that 67 patients (64%) reported knee instability during daily living activities, and 47 (45%) reported that instability affects their physical function (*Arthritis Rheum.* 2004;51:941-6).

A gait analysis of 48 patients, led by colleague John D. Childs, Ph.D., found that those with knee OA had reduced knee flexion and extension movements and significant increases in muscle co-contractions during walking.

The vastus lateralis, medial hamstrings, tibialis anterior, and medial gastrocnemius were activated about 1.5 times longer than the same muscles in controls (*Clin. Biomech.* [Bristol, Avon] 2004;19:44-9).

To keep their knee stable, patients will often freeze their

range of motion and simplify the steps necessary to perform a movement.

The combination of restricted knee movement and increased co-contractions puts additional stress on the joint, which in turn can accelerate OA disease progression.

The same interventions used to promote knee stability in athletes with knee ligament injuries can be modified to improve knee stability and function in people with knee OA, said Dr. Fitzgerald, who recommended adding agility and perturbation exercises twice a week to a traditional strengthening and stretching program.

Perturbation techniques that for athletes involve a therapist rocking a roller or tilt board while the patient stands on it are done with the OA patient sitting down or while standing on both legs, rather than just one leg.

Exposing the patient's knee to such unpredictable and varied stresses can help expand movement patterns and boost the patient's confidence to perform more complex movements, he said.

The exercises have been tried in a handful of knee OA patients, who were then able to return to higher levels of physical activity with less pain and instability following rehabilitation.

—Patrice Wendling